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CENTRAL DIST. OF CALIF.  
LOS ANGELES

BY: \_\_\_\_\_

UNITED STATES DISTRICT COURT  
FOR THE CENTRAL DISTRICT OF CALIFORNIA

October 2014 Grand Jury

UNITED STATES OF AMERICA,

Plaintiff,

v.

JOSEPH R. ALTAMIRANO,

Defendant.

No. CR 15-

**CR15 - 0321**

I N D I C T M E N T

[18 U.S.C. § 1349: Conspiracy to  
Commit Health Care Fraud;  
18 U.S.C. § 1347: Health Care  
Fraud; 18 U.S.C. § 2(b): Causing  
an Act to be Done]

The Grand Jury charges:

COUNT ONE

[18 U.S.C. § 1349]

A. INTRODUCTORY ALLEGATIONS

At all times relevant to this Indictment:

1. Defendant JOSEPH R. ALTAMIRANO, M.D. ("ALTAMIRANO")  
was a physician who owned, operated, and oversaw a medical  
clinic located at 5300 Santa Monica Blvd., Suite 202, Los  
Angeles, California, within the Central District of California  
(the "Altamirano Clinic").

1           2.    Co-conspirator "CC-1" was the office manager and  
2 biller for the Altamirano Clinic.

3           3.    Co-conspirator "CC-2" was a "marketer" who recruited  
4 Medicare beneficiaries for the Altamirano Clinic.

5           The Medicare Program

6           4.    Medicare was a federal health care benefit program,  
7 affecting commerce, that provided benefits to individuals who  
8 were 65 years and older or disabled. Medicare was administered  
9 by the Centers for Medicare and Medicaid Services ("CMS"), a  
10 federal agency under the United States Department of Health and  
11 Human Services. Medicare was a "health care benefit program" as  
12 defined by Title 18, United States Code, Section 24(b).

13          5.    Individuals who qualified for Medicare benefits were  
14 referred to as Medicare "beneficiaries." Each beneficiary was  
15 given a unique health insurance claim number ("HICN"). Home  
16 health agencies ("HHAs"), hospices, durable medical equipment  
17 ("DME") supply companies, physicians, and other health care  
18 providers that provided medical services that were reimbursed by  
19 Medicare were referred to as Medicare "providers."

20          6.    To participate in Medicare, providers were required to  
21 submit an application in which the provider agreed to comply  
22 with all Medicare-related laws and regulations. If Medicare  
23 approved a provider's application, Medicare assigned the  
24 provider a Medicare "provider number," which was used for  
25 processing and payment of claims.

26          7.    A health care provider with a Medicare provider number  
27 could submit claims to Medicare to obtain reimbursement for  
28 services rendered to Medicare beneficiaries.

1       8. Most providers submitted their claims electronically  
2 pursuant to an agreement they executed with Medicare in which  
3 the providers agreed that: (a) they were responsible for all  
4 claims submitted to Medicare by themselves, their employees, and  
5 their agents; (b) they would submit claims only on behalf of  
6 those Medicare beneficiaries who had given their written  
7 authorization to do so; and (c) they would submit claims that  
8 were accurate, complete, and truthful.

9       9. Medicare generally reimbursed a provider for physician  
10 services that were medically necessary to the health of the  
11 beneficiary and were personally furnished by the physician or  
12 the physician's employee under the physician's direction.

13       10. Medicare generally reimbursed a provider for DME only  
14 if the DME was prescribed by the beneficiary's physician, the  
15 DME was medically necessary to the treatment of the  
16 beneficiary's illness or injury, and the DME supply company  
17 provided the DME in accordance with Medicare regulations and  
18 guidelines, which governed whether Medicare would reimburse a  
19 particular item or service. For power wheelchairs ("PWCs"),  
20 Medicare required the DME supply company to have and maintain  
21 documentation showing that the physician ordering the PWC  
22 performed a face-to-face evaluation of the patient.

23       11. Medicare generally reimbursed a provider for home  
24 health services only if, among other requirements, the Medicare  
25 beneficiary was homebound and did not have a willing caregiver  
26 to assist him or her; the beneficiary needed skilled nursing  
27 services or physical or occupational therapy services; the  
28 beneficiary was under the care of a qualified physician who

1 established a Plan of Care (CMS Form 485) for the beneficiary,  
2 signed by the physician and also signed by a registered nurse  
3 ("RN") from the HHA; and the skilled nursing services or  
4 physical or occupational therapy were medically necessary.

5 12. CMS contracted with regional contractors to process  
6 and pay Medicare claims. Noridian Administrative Services  
7 ("Noridian") was the contractor that processed and paid Medicare  
8 DME claims in Southern California during the relevant time  
9 period. Noridian was the contractor that processed claims  
10 involving Medicare Part B physician services in Southern  
11 California from approximately September 2013 to the present.  
12 Prior to Noridian, the contractor for Part B physician services  
13 was Palmetto GBA from 2009 to 2013. Prior to Palmetto GBA, the  
14 contractor for Part B physician services was National Health  
15 Insurance Company from 2005 to 2009. National Government  
16 Services ("NGS") was the contractor that processed and paid  
17 Medicare claims for home health services in Southern California  
18 during the relevant time period.

19 13. To bill Medicare for physician services or DME  
20 provided to a beneficiary, a provider was required to submit a  
21 claim form (Form 1500) to the Medicare contractor processing  
22 claims at that time. To bill Medicare for home health services,  
23 a provider was required to submit a claim form (Form UB-04) to  
24 NGS. When a Form 1500 or Form UB-04 was submitted, usually in  
25 electronic form, the provider was required to certify:

26 a. that the contents of the form were true, correct,  
27 and complete;

1           b.     that the form was prepared in compliance with the  
2 laws and regulations governing Medicare; and

3           c.     that the services being billed were medically  
4 necessary.

5           14.    A Medicare claim for payment was required to set  
6 forth, among other things, the following: the beneficiary's name  
7 and unique Medicare identification number; the type of services  
8 provided to the beneficiary; the date that the services were  
9 provided; and the name and Unique Physician Identification  
10 Number ("UPIN") or National Provider Identifier ("NPI") of the  
11 physician who prescribed or ordered the services.

12    B.    THE OBJECT OF THE CONSPIRACY

13           15.    Beginning in or around January 2005, and continuing  
14 through in or around May 2015, in Los Angeles County, within the  
15 Central District of California, and elsewhere, defendant  
16 ALTAMIRANO, together with CC-1, CC-2, and others known and  
17 unknown to the Grand Jury, knowingly combined, conspired, and  
18 agreed to commit health care fraud, in violation of Title 18,  
19 United States Code, Section 1347.

20    C.    THE MANNER AND MEANS OF THE CONSPIRACY

21           16.    The object of the conspiracy was carried out, and to  
22 be carried out, in substance, as follows:

23           a.     In or around January 2005, defendant ALTAMIRANO  
24 opened a bank account at Washington Mutual Bank, account number  
25 \*\*\*\* 5319 (the "WaMu Account"). Defendant ALTAMIRANO was the  
26 sole signatory on this account.

1           b. In or around February 2005, defendant ALTAMIRANO  
2 began submitting claims to Medicare and depositing checks from  
3 Medicare into the WaMu Account.

4           c. In or around May 2011, defendant ALTAMIRANO added  
5 co-conspirator CC-1 as a signatory on the WaMu Account.

6           d. In or around August 2011, defendant ALTAMIRANO  
7 opened a bank account at Wells Fargo Bank, account number \*\*\*\*  
8 4663 (the "Wells Fargo Account"). Defendant ALTAMIRANO and co-  
9 conspirator CC-1 were signatories on this account. Medicare  
10 payments for the Altamirano Clinic were subsequently deposited  
11 into this account.

12           e. In or around August 2013, defendant ALTAMIRANO  
13 submitted to Medicare a revalidation application for the  
14 Altamirano Clinic. In this application, defendant ALTAMIRANO  
15 listed himself as an individual practitioner and sole contact  
16 for the Altamirano Clinic.

17           f. Individuals known as "marketers," including CC-2,  
18 traveled throughout Southern California to recruit Medicare  
19 beneficiaries and take them to the Altamirano Clinic. To induce  
20 the beneficiaries, the marketers told the beneficiaries, among  
21 other things, that Medicare had a limited-time offer for free  
22 PWCs and that the beneficiaries could receive free vitamins.

23           g. The marketers, including CC-2, brought Medicare  
24 beneficiaries to the Altamirano Clinic so that defendant  
25 ALTAMIRANO could write medically unnecessary prescriptions for  
26 DME and medically unnecessary certifications for home health  
27 services.

1           h.    At times, while the beneficiaries were at the  
2 Altamirano Clinic, conspirators provided them with certain  
3 medically unnecessary services, including blood draws and  
4 ultrasounds. At other times, conspirators gave the  
5 beneficiaries toenail trimmings and foot massages. At still  
6 other times, the beneficiaries received few or no services.

7           i.    At times, while the beneficiaries were at the  
8 Altamirano Clinic, defendant ALTAMIRANO met with them briefly,  
9 but often did not physically examine them. At other times, the  
10 beneficiaries did not meet defendant ALTAMIRANO at all.

11           j.    Subsequently, defendant ALTAMIRANO and his co-  
12 conspirators, including co-conspirator CC-1 and others known and  
13 unknown to the Grand Jury, submitted and caused the submission  
14 of false and fraudulent claims to Medicare for services that, as  
15 defendant ALTAMIRANO then well knew, were not provided to the  
16 beneficiaries, including, depending on the beneficiary, nerve  
17 conduction velocity studies ("NCVs"), removal of finger and toe  
18 tissue, office visits, physical therapy, and some ultrasounds.  
19 These beneficiaries included D.B., G.R., and L.H.

20           k.    Defendant ALTAMIRANO signed prescriptions for DME  
21 items, including PWCs and related accessories, that defendant  
22 ALTAMIRANO then well knew were not medically necessary.  
23 Defendant ALTAMIRANO provided these prescriptions to CC-2 and  
24 other co-conspirators known and unknown to the Grand Jury.  
25 Defendant ALTAMIRANO also knew that these prescriptions would be  
26 used to submit fraudulent claims to Medicare for DME, including  
27 PWCs and related accessories. The beneficiaries in whose names  
28 these claims were submitted include B.A., C.A., G.R., G.S., and

1 M.H.

2 1. In addition, defendant ALTAMIRANO signed home  
3 health certifications that defendant ALTAMIRANO then well knew  
4 were not medically necessary. Defendant ALTAMIRANO provided  
5 these certifications to other co-conspirators, so that they  
6 could be used by HHAs to submit false and fraudulent claims to  
7 Medicare for home health services.

8 m. As a result of the submission of the false and  
9 fraudulent claims described above, Medicare made payments by  
10 check to Altamirano, as well as payments to numerous bank  
11 accounts, including the Wells Fargo Account, on which defendant  
12 ALTAMIRANO was a signatory.

13 17. Between in or around January 2006, and in or around  
14 September 2014, defendant ALTAMIRANO and his co-conspirators  
15 submitted and caused the submission of approximately \$22,788,117  
16 in claims to Medicare, resulting in Medicare payments of  
17 approximately \$12,641,373.

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COUNTS TWO THROUGH THREE

[18 U.S.C. §§ 1347, 2(b)]

A. INTRODUCTORY ALLEGATIONS

18. The Grand Jury incorporates by reference and re-alleges paragraphs 1 through 14 of this Indictment as though set forth in their entirety herein.

B. THE SCHEME TO DEFRAUD

19. Beginning in or around January 2005, and continuing through in or around May 2015, in Los Angeles County, within the Central District of California, and elsewhere, defendant ALTAMIRANO, together with CC-1, CC-2, and others known and unknown to the Grand Jury, knowingly, willfully, and with intent to defraud, executed, and attempted to execute, a scheme and artifice: (a) to defraud a health care benefit program, namely Medicare, as to material matters in connection with the delivery of and payment for health care benefits, items, and services; and (b) to obtain money from Medicare by means of material false and fraudulent pretenses and representations and the concealment of material facts in connection with the delivery of and payment for health care benefits, items, and services.

C. MEANS TO ACCOMPLISH THE SCHEME TO DEFRAUD

20. The fraudulent scheme operated, in substance, as described in paragraph 16 of this Indictment, which is hereby incorporated by reference as though set forth in its entirety herein.

1 D. THE EXECUTION OF THE FRAUDULENT SCHEME

2 21. On or about the dates set forth below, within the  
3 Central District of California, and elsewhere, defendant  
4 ALTAMIRANO, together with CC-1, CC-2, and others known and  
5 unknown to the Grand Jury, for the purpose of executing and  
6 attempting to execute the fraudulent scheme described above,  
7 knowingly and willfully submitted and caused to be submitted to  
8 Medicare for payment the following false and fraudulent claims:  
9

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11 ///

12 ///

<u>COUNT</u>	<u>BENEFICIARY</u>	<u>CLAIM NUMBER</u>	<u>APPROX. DATE SUBMITTED</u>	<u>APPROX. AMOUNT OF CLAIM</u>
TWO	L.H.	551111116002990	4/21/11	\$797.00
THREE	D.B.	551111283230230	4/21/12	\$702.00

A TRUE BILL

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Foreperson

STEPHANIE YONEKURA  
Acting United States Attorney

ROBERT E. DUGDALE  
Assistant United States Attorney  
Chief, Criminal Division

RICHARD E. ROBINSON  
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